		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028605

Facility Name: Rest Haven West Christian Nursing Center

Address: 3450 Saratoga Avenue (Number) Downers Grove (City) 60515 (Zip Code)

County: DuPage

Telephone Number: (630) 969-2900 **Fax #** (630) 969-2148

IDPA ID Number: 362382853003

Date of Initial License for Current Owners: 05/01/84

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(C)3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael G. Kaplan **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	53,070	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	96	Sheltered Care (SC)	96	35,136	5
6		ICF/DD 16 or Less			6
7	241	TOTALS	241	88,206	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,512	1,000	6,418	8,930	8
9	SNF/PED					9
10	ICF	15,371	23,807		39,178	10
11	ICF/DD					11
12	SC		30,576		30,576	12
13	DD 16 OR LESS					13
14	TOTALS	16,883	55,383	6,418	78,684	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.20%

D. How many bed-hold days during this year were paid by Public Aid? 13 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 05/01/84

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 05/01/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 24 and days of care provided 5,590

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	593,530	80,239	1,000	674,769		674,769		674,769			1
2	Food Purchase		443,159		443,159		443,159	(13,486)	429,673			2
3	Housekeeping	241,079	32,614		273,693		273,693		273,693			3
4	Laundry	73,616	17,915		91,531		91,531		91,531			4
5	Heat and Other Utilities			182,027	182,027		182,027	2,506	184,533			5
6	Maintenance	83,320		191,207	274,527		274,527	966	275,493			6
7	Other (specify):*											7
8	**TOTAL General Services**	991,545	573,927	374,234	1,939,706		1,939,706	(10,014)	1,929,692			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	2,790,540	195,028	86,105	3,071,673		3,071,673		3,071,673			10
10a	Therapy			465,071	465,071		465,071	(39,029)	426,042			10a
11	Activities	167,593	20,387	1,932	189,912		189,912		189,912			11
12	Social Services	110,390	83	4,214	114,687		114,687		114,687			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,068,523	215,498	571,722	3,855,743		3,855,743	(39,029)	3,816,714			16
	C. General Administration											
17	Administrative	67,775		274,787	342,562		342,562	(274,787)	67,775			17
18	Directors Fees											18
19	Professional Services			28,441	28,441		28,441	1,807	30,248			19
20	Dues, Fees, Subscriptions & Promotions			53,103	53,103		53,103	(19,076)	34,027			20
21	Clerical & General Office Expenses	457,908	7,835	58,314	524,057		524,057	48,025	572,082			21
22	Employee Benefits & Payroll Taxes			606,247	606,247		606,247	67,428	673,675			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,629	12,629		12,629	15,364	27,993			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			34,857	34,857		34,857	1,813	36,670			26
27	Other (specify):*											27
28	**TOTAL General Administration**	525,683	7,835	1,068,378	1,601,896		1,601,896	(159,426)	1,442,470			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,585,751	797,260	2,014,334	7,397,345		7,397,345	(208,469)	7,188,876			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Rest Haven West Christian Nursing Center #0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			505,016	505,016		505,016	(8,709)	496,307			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			295,754	295,754		295,754		295,754			32
33	Real Estate Taxes			14,368	14,368		14,368	(14,368)				33
34	Rent-Facility & Grounds							7,904	7,904			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			815,138	815,138		815,138	(15,173)	799,965			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		383,895	17,996	401,891		401,891		401,891			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,300	78,300		78,300		78,300			42
43	Other (specify):* Nonallowable costs			254,747	254,747		254,747	(254,747)				43
44	**TOTAL Special Cost Centers**		383,895	351,043	734,938		734,938	(254,747)	480,191			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,585,751	1,181,155	3,180,515	8,947,421		8,947,421	(478,389)	8,469,032			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,786)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(33,530)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(230)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(15,457)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,838)	43		24
25	Fund Raising, Advertising and Promotional	(100,994)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(25,253)	43		28
29	Other-Attach Schedule See Schedule 5A	(186,876)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (390,964)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(87,425)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (87,425)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (478,389)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Rest Haven West Christian Nursing Center

ID# 0028605

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rest Haven Illiana Christian Convalescent Home	100.00%	Rest Haven Central	Palos Heights, IL	Holland Home	South Holland	Sheltered Care
		Rest Haven South	South Holland, IL	Village Woods	Crete	Independent Ret.
				Providence Mgmt. & Development Co.	South Holland	Management Co.
				Providence Home Health Care	South Holland	Home Health

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Rest Haven Illiana Christian Convalescent Home	100.00%	$ 2,506	$ 2,506	1
2	V	6	Maintenance supplies		Rest Haven Illiana Christian Convalescent Home	100.00%	966	966	2
3	V	17	Management fees	274,787	Rest Haven Illiana Christian Convalescent Home	100.00%		(274,787)	3
4	V	19	Professional services		Rest Haven Illiana Christian Convalescent Home	100.00%	1,789	1,789	4
5	V	20	Licenses, dues & subscriptions		Rest Haven Illiana Christian Convalescent Home	100.00%	3,418	3,418	5
6	V	21	Office		Rest Haven Illiana Christian Convalescent Home	100.00%	60,889	60,889	6
7	V	22	Employee benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	67,892	67,892	7
8	V	24	Travel & seminar		Rest Haven Illiana Christian Convalescent Home	100.00%	15,364	15,364	8
9	V	26	Insurance		Rest Haven Illiana Christian Convalescent Home	100.00%	1,813	1,813	9
10	V	30	Depreciation		Rest Haven Illiana Christian Convalescent Home	100.00%	24,821	24,821	10
11	V	34	Rent		Rest Haven Illiana Christian Convalescent Home	100.00%	7,904	7,904	11
12	V								12
13	V								13
14	Total			$ 274,787			$ 187,362	$ * (87,425)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4	See Schedule 7A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Rest Haven Illiana Christian Convalescent
Street Address: 12450 West Cheshire Court
City / State / Zip Code: Lockport, IL 60441
Phone Number: (630) 645-2115
Fax Number: (630) 877-2103

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Accumulated Cost	47,898,540	11	$ 14,293	$	8,397,269	$ 2,506	1
2	6	Maintenance supplies	Accumulated Cost	47,898,540	11	5,512		8,397,269	966	2
3	19	Professional services	Accumulated Cost	47,898,540	11	10,207		8,397,269	1,789	3
4	20	Licenses, dues & subscriptions	Accumulated Cost	47,898,540	11	19,497		8,397,269	3,418	4
5	21	Office	Accumulated Cost	47,898,540	11	347,138		8,397,269	60,858	5
6	21	Office	Accumulated Cost	36,110,598	8	132		8,397,269	31	6
7	22	Employee benefits	Accumulated Cost	47,898,540	11	336,161		8,397,269	58,933	7
8	22	Employee benefits	Direct Cost	1	1	79,694		1	8,959	8
9	24	Travel & seminar	Accumulated Cost	47,898,540	11	87,639		8,397,269	15,364	9
10	26	Insurance	Accumulated Cost	47,898,540	11	10,341		8,397,269	1,813	10
11	30	Depreciation	Accumulated Cost	47,898,540	11	141,584		8,397,269	24,821	11
12	34	Rent	Accumulated Cost	47,898,540	11	45,086		8,397,269	7,904	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,097,284	$		$ 187,362	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Tax Exempt Bonds		x	Additions and renovations	$48,450.00	02/26/97	$ 5,515,700	$ 5,356,100	07/01/12	0.0536	$ 294,497	1
2	Direct Obligation Notes		x	Remodeling	Interest Only	02/26/97	763,564	28,815	Various	0.0707	1,257	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$48,450.00		$ 6,279,264	$ 5,384,915			$ 295,754	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,279,264	$ 5,384,915			$ 295,754	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

This facility does not have real estate taxes because it is a not-for-profit organization.

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 105,900 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	29,200	1984	$ 339,570	1
2					2
3	TOTALS	29,200		$ 339,570	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	241		1984	1962	$ 86,903	$ 2,172	40	$ 2,172	$	$ 84,741	4
5				1972	889,527	22,238	40	22,238		644,902	5
6				1973	34,742	869	40	869		24,332	6
7				1974	7,414	185	40	185		4,995	7
8				1975	55,878	1,397	40	1,397		36,322	8
	Improvement Type**										
9	Improvement			1976	4,115	103	40	103		2,575	9
10	Improvement			1977	33,527	838	40	838		20,112	10
11	Improvement			1980	6,049	151	40	151		3,171	11
12	Improvement			1981	7,380	185	40	185		3,700	12
13	Improvement			1983	22,839	571	40	571		10,278	13
14	Improvement			1984	370,014	9,250	40	9,250		157,250	14
15	Improvement			1985	297,491	7,437	40	7,437		118,992	15
16	Improvement			1986	275,406	6,885	40	6,885		103,275	16
17	Improvement			1987	24,035	601	40	601		8,414	17
18	Improvement			1988	509,896	12,747	40	12,747		165,711	18
19	Improvement			1989	4,381,420	109,536	40	109,536		1,314,432	19
20	Improvement			1989	90,660	2,267	40	2,267		27,204	20
21	Improvement			1990	155,196	3,880	40	3,880		42,680	21
22	Improvement			1991	5,021	126	40	126		1,260	22
23	Improvement			1992	75,453	1,886	40	1,886		16,974	23
24	Improvement			1993	26,281	657	40	657		5,256	24
25	Improvement			1994	16,231	405	40	405		2,835	25
26	Improvement			1995	128,962	3,224	40	3,224		17,732	26
27	Sign and landscaping			1996	4,764	119	40	119		536	27
28	Fence			1996	1,565	40	40	40		180	28
29	Renovate laundry and break rooms			1996	4,400	110	40	110		495	29
30	Whirlpool tubs			1996	20,200	505	40	505		2,272	30
31	Side rails			1996	2,293	57	40	57		257	31
32	Phone system			1996	35,085	877	40	877		3,946	32
33	Parking Lot			1997	15,078	377	40	377		1,320	33
34	Landscaping			1997	10,839	271	40	271		948	34
35	Dining room renovation			1997	1,193	30	40	30		105	35
36	TOTAL (lines 4 thru 35)				$ 7,599,857	$ 189,996		$ 189,996	$	$ 2,827,202	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Hospitality room renovation			1997	34,830	871	40	871		3,048	9
10	Activity / class room renovation			1997	3,476	87	40	87		304	10
11	Carpeting			1997	1,521	38	40	38		133	11
12	Railing			1997	500	13	40	13		45	12
13	Laundry / break room renovation			1998	6,864	172	40	172		430	13
14	Compressor			1998	917	92	10	92		230	14
15	Roof repair			1998	2,320	232	10	232		580	15
16	Alarm system			1998	1,056	106	10	106		265	16
17	Hospitality room renovation			1998	12,605	316	40	316		790	17
18	Carpeting			1998	76,503	15,300	5	15,300		38,250	18
19	Wallpaper			1998	40,287	8,058	5	8,058		20,145	19
20	Book depreciation on assets disallowed for Medicaid			1999		65,728			(65,728)		20
21	Roofing			1999	208,749	20,874	10	20,874		31,311	21
22	Therapy room renovation			1999	23,731	2,374	10	2,374		3,561	22
23	Resident room lighting			1999	23,965	2,396	10	2,396		3,594	23
24	Phone upgrade			1999	2,470	248	10	248		372	24
25	Renovations			1999	47,385	4,738	10	4,738		7,108	25
26	Prior year disposal being researched				(116,300)					(27,598)	26
27	New door on oxygen room			1999	1,993	194	10	194		292	27
28	Landscaping			2000	59,350	742	40	742		742	28
29	Benches			2000	2,500	31	40	31		31	29
30	Room 18 renovation, wallcover, painting, tiling and carpeting			2000	7,682	384	10	384		384	30
31	Therapy renovation, wallcover, painting and tiling			2000	28,849	1,442	10	1,442		1,442	31
32	Beauty & barber renovation, wallcover, painting, tiling and carpeting			2000	31,764	1,588	10	1,588		1,588	32
33	Common renovation, wallcover, painting, tiling, and carpeting			2000	42,312	2,116	10	2,116		2,116	33
34	Kitchen renovation, wallcover, painting, and tiling			2000	24,995	1,250	10	1,250		1,250	34
35	HVAC			2000	32,028	1,601	10	1,601		1,601	35
36	TOTAL (lines 4 thru 35)				$ 602,352	$ 130,991		$ 65,263	$ (65,728)	$ 92,014	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Doors			2000	3,300	165	10	165		165	9
10	Countertop			2000	654	33	10	33		33	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 3,954	$ 198		$ 198	$	$ 198	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 2,001,706	$ 159,947	$ 201,763	$ 41,816	10	$ 1,476,213	37
38	Current Year Purchases	195,334	9,767	9,767		10	9,767	38
39	Fully Depreciated Assets							39
40	Home Office Allocation			24,821	24,821			40
41	TOTALS	$ 2,197,040	$ 169,714	$ 236,351	$ 66,637		$ 1,485,980	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Care	1984 Ford Bus	1989	$ 47,590	$	$	$	5	$ 47,590	42
43	Resident Care	1995 Chevrolet K20 Truck	1995	22,494	14,117	4,499	(9,618)	5	24,743	43
44										44
45										45
46	TOTALS			$ 70,084	$ 14,117	$ 4,499	$ (9,618)		$ 72,333	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 10,812,857	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 505,016	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 496,307	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (8,709)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 4,477,727	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Home Office Allocation				7,904			6
7	TOTAL				$ 7,904 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [x] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C8	hrs	$	4,522	$ 170,422	$	4,522	$ 170,422	1
2	Licensed Speech and Language Development Therapist	L10a, C8	hrs		1,125	47,094		1,125	47,094	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C8	hrs		4,417	208,526		4,417	208,526	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				383,895		383,895	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Laboratory	L39, C3				17,996			17,996	13
14	TOTAL			$	10,064	$ 444,038	$ 383,895	10,064	$ 827,933	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center **#** 0028605 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,200	$ 1,200	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (121,828))	1,279,609	1,279,609	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	16,000	16,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,296,809	$ 1,296,809	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	358,918	339,570	13
14	Buildings, at Historical Cost	9,303,399	8,206,163	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,272,039	2,267,124	16
17	Accumulated Depreciation (book methods)	(5,541,224)	(4,477,727)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,393,132	$ 6,335,130	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,689,941	$ 7,631,939	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 201,542	$ 201,542	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	531	531	28
29	Short-Term Notes Payable	28,815	28,815	29
30	Accrued Salaries Payable	252,332	252,332	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,860	2,860	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	4,380,374	4,380,374	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,866,454	$ 4,866,454	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		5,356,100	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,356,100	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,866,454	$ 10,222,554	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,823,487	$ (2,590,615)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,689,941	$ 7,631,939	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,474,236	1
2	Restatements (describe):		2
3	**Prior Year Adjustment per Auditor**	(38,119)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,436,117	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	387,370	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 387,370	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,823,487	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,378,254	1
2	Discounts and Allowances for all Levels	(2,330,720)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,047,534	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,657,150	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,657,150	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	10,786	14
15	Telephone, Television and Radio	930	15
16	Rental of Facility Space		16
17	Sale of Drugs	335,140	17
18	Sale of Supplies to Non-Patients	13,934	18
19	Laboratory	40,598	19
20	Radiology and X-Ray	4,450	20
21	Other Medical Services	204,253	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 610,091	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	20,016	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 20,016	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,334,791	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,939,706	31
32	Health Care	3,855,743	32
33	General Administration	1,601,896	33
	B. Capital Expense		
34	Ownership	815,138	34
	C. Ancillary Expense		
35	Special Cost Centers	656,638	35
36	Provider Participation Fee	78,300	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,947,421	40
41	**Income before Income Taxes (line 30 minus line 40)****	387,370	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 387,370	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,876	2,080	$ 61,243	$ 29.44	1
2	Assistant Director of Nursing	1,064	1,096	24,377	22.24	2
3	Registered Nurses	29,466	31,945	753,850	23.60	3
4	Licensed Practical Nurses	20,860	22,288	408,215	18.32	4
5	Nurse Aides & Orderlies	108,595	116,465	1,435,327	12.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,459	15,077	167,593	11.12	10
11	Social Service Workers	8,271	9,350	110,390	11.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	52,777	55,970	593,530	10.60	15
16	Dishwashers					16
17	Maintenance Workers	5,075	5,356	83,320	15.56	17
18	Housekeepers	22,342	24,211	241,079	9.96	18
19	Laundry	7,631	8,072	73,616	9.12	19
20	Administrator	2,000	2,080	67,775	32.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,695	21,523	457,908	21.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,987	2,063	23,954	11.61	31
32	Other Health Care(specify) See 20A	4,194	4,447	83,574	18.79	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	299,292	322,023	$ 4,585,751 *	$ 14.24	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	1,000	L1, C3	35
36	Medical Director	144	14,400	L9, C3	36
37	Medical Records Consultant	96	4,032	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	1,768	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	1,932	L11, C3	44
45	Social Service Consultant	96	2,655	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	440	$ 25,787		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	356	$ 15,940	L10, C3	50
51	Licensed Practical Nurses	1,289	46,150	L10, C3	51
52	Nurse Aides	978	15,244	L10, C3	52
53	TOTAL (lines 50 - 52)	2,623	$ 77,334		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Catherine DeVries	Administrator	0.00%	$ 67,775
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,775

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 274,787
TOTAL (agree to Schedule V, line 17, col. 3)	$ 274,787
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Altschuler, Melvoin & Glasser,LLP	Accounting	9,290
KPMG Peat Marwick LLP	Accounting	8,500
Laner, Muchin, Dombrow, Becker,		
Levin and Tominberg, Ltd.	Legal	2,034
Katten Muchin & Zavis	Legal	1,568
Amherst Senior Living	Consulting	396
Bain Environment	Consulting	75
Achieve Accreditation	Consulting	4,033
Alternative Staffing Resource	Consulting	2,500
AMA Profile	Consulting	45
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 28,441

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,130
Unemployment Compensation Insurance	5,222
FICA Taxes	317,225
Employee Health Insurance	40,397
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Welfare	124,969
Employee Vaccinations/Medical	4,013
Drug Testing	5,091
TDA Expense	56,106
Employee Education	1,630
Home Office Allocation	67,892
TOTAL (agree to Schedule V, line 22, col.8)	$ 673,675

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,580
Health Care Worker Background Check	
(Indicate # of checks performed 81)	564
Life Services Network	9,698
Health Resources Alliance	10,800
Miscellaneous Licenses and Dues	1,050
Miscellaneous Subscriptions	917
Home Office Allocation	3,418
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,027

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	12,629
Home Office Allocation	15,364
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 27,993

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1								$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN: $9,698; HRA: $10,800**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,766** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **78,300**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **10,786**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records are maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG Peat Marwick LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit in Progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.